IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

August 21, 2007

Tom Whittemore
Communicare, Inc. #1 Gem
40 West Franklin Road Suite F
Meridian, Idaho 83642

RE: Communicare, Inc. #1 Gem, provider #13G008

Dear Mr. Whittemore:

This is to advise you of the findings of the Medicaid/Licensure survey, which was concluded at your facility, Communicare, Inc. #1 Gem, on August 9, 2007.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 3, 2007**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by September 3, 2007. If a request for informal dispute resolution is received after September 3, 2007, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

LOIS HOLLINGSWORTH
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Supervisor
Non-Long Term Care

LH/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G008	A. BUILDING _____ B. WING _____	08/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNICARE, INC #1 (GEM)	32 N GEM STREET NAMPA, ID 83651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during your recertification survey. The surveyors conducting your survey were: Lois Hollingsworth, RN, Team Leader Monica Williams, QMRP/HFS Common abbreviations used in this report are: BMP - Behavior Management Plan HM - Home Manager IDT - Interdisciplinary Team IPP - Individual Program Plan NOS - Not Otherwise Specified OT - Occupational Therapist QMRP - Qualified Mental Retardation Professional	W 000		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individuals' active treatment programs were not delayed for 2 of 4 individuals (Individuals #2 and 3) whose evaluations and IPPs were reviewed. This resulted in individuals not receiving services and related training as recommended by	W 249	W249 Corrective Actions: Individual #2 will participate in social sexual training offered either through a community provider or through data based training provided at the facility; objectives will be added for Individual #3 related to use of a visual calendar to support independence and increase compliance and matching objects and pictures. Identifying Others Potentially Affected: Records will be reviewed for all individuals at this location related to professional's recommendations using our revised Quality Assurance Review format (see attached). System Changes: Implementation of revised Quality Assurance Review system. The QMRP will be complete this system on at least a semi-annual basis. Monitoring: The QMRP will submit a copy of completed QA forms to the QMRP Supervisor for review. The QMRP Supervisor or designee will complete at least one QA review per location twice per year as a supplemental QA process.	10-9-07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] | Administrator | 9-4-07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 249	Continued From page 1 professional evaluations. The findings include: 1. Individual #2's IPP, dated 6/21/07, documented a 21 year old female diagnosed with moderate mental retardation and Down Syndrome. Individual #2's Psychological Evaluation, dated 6/15/07, stated "During a class on sex education class in [high school], this young woman indicated that she had had inappropriate touching within her family. An investigation is reported to have found no evidence of sexual maltreatment. Later, after she had moved to [facility], she again indicated inappropriate touching. Reportedly, an investigation did not support the allegations. In 2005, this young woman moved from her initial coed housing placement to an all women's home with [the company who owns the facility]. She has lived in the all women's home now for two years. According to the staff in the home, [Individual #2] is more verbal and more interactive than any of the other consumers. She prefers to socialize with staff." The Psychological Evaluation included a recommendation which stated "It is recommended that this young adult be involved in a developmentally appropriate sexuality curriculum. She needs to express her sexual interests appropriately." Individual #2's IPP included a "Programmatic Need" related to social-sexual training. When asked, the QMRP stated during an interview on 8/9/07 from 10:00 - 10:45 a.m., Individual #2 was involved in an "informal" curriculum. When asked the meaning of "informal", the QMRP stated a standardized/professional sexuality curriculum was not being used. The Home Manager, who	W 249		

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W 249	Continued From page 2 was present during the interview, stated that at one time, Individual #2 had two boyfriends but was told by facility staff that she had to pick only one, and that having two boyfriends was "weird". When asked about personal bias being communicated to Individual #2, the QMRP stated a curriculum would help alleviate that problem. 2. Per her 6/28/07 IPP, Individual #3 was a 54 year old female diagnosed with moderate mental retardation and chronic undifferentiated schizophrenia. Individual #3's Speech and Language Report, dated 9/23/06, stated she "participates in activities of daily living supported with verbal cues," and that "when frustrated (Individual #3) will pinch, yell, hit, and kick." The Speech Language Pathologist made the following recommendations: - Use a visual daily calendar to support independence. - Match object pictures with object functions to increase vocabulary knowledge. Individual #3's Occupational Therapy Report, dated 3/20/07, made the following recommendation: - Using a picture schedule may decrease behaviors and increase compliance and independence due to increased understanding of visual cues. Start with a familiar task, such as grooming. OT will assist with this if requested. The QMRP was asked during interview conducted on 8/9/07, from 10:40 a.m. - 11:05	W 249		

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W 249	Continued From page 3 a.m., if those professionals' recommendations had been implemented in the home setting. The QMRP stated that they had not. The QMRP was not able to provide the IDT's rationale for not doing so. Individual #3's IPP included a "Programmatic Need" related to developing a personal daily schedule.	W 249		
W 260	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individuals' IPPs reflected and responded to functional changes for 1 of 4 individuals (Individual #1) whose evaluations and IPP was reviewed. This resulted in an individual not receiving services and related training as recommended by professional evaluations. The findings include: 1. Individual #1's IPP, dated 6/7/07, documented a 40 year old female diagnosed with severe mental retardation and Lennox-Gastaut Syndrome. Individual #1's Speech Language Evaluation, dated 9/24/06, stated Individual #1 primarily communicated with touch, yelling, and pointing. The Speech Language Evaluation stated visual picture supports would help facilitate Individual #1's understanding of the world around her and allow her the ability to communicate her desires and basic needs without staff having to guess her	W 260	W260 Corrective Actions: The speech therapist recommendations for Individual #1 related to use of a communication board system will be implemented through data based training. Identifying Others Potentially Affected: Records will be reviewed for all individuals at this location related to professional's recommendations using our revised Quality Assurance Review format (see attached). System Changes: Implementation of revised Quality Assurance Review system. The QMRP will be complete this system on at least a semi-annual basis. Monitoring: The QMRP will submit a copy of completed QA forms to the QMRP Supervisor for review. The QMRP Supervisor or designee will complete at least one QA review per location twice per year as a supplemental QA process.	10-1-07

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W 260	Continued From page 4 wants and desires. The Speech Language Evaluation included recommendations to "Establish the use of a simple communication choice board with real pictures of basic needs and desires (eat, drink, sleep, music, magazines, and swing) to establish functional communication...Match real objects with real object pictures to facilitate object identification to increase the success in using the choice board...Use a visual calendar (with real pictures) to show [Individual #1] her daily activities...and...Label hazardous areas of the house with a "no touch" picture icon to increase safety and to increase [Individual #1's] understand [sic] of why she can't be in a certain areas [sic]." When asked about the communication choice board, a direct care staff at the facility stated on 8/7/07 at 2:15 p.m., Individual #1 did not have a communication board. When asked about the four above noted recommendations, the QMRP stated during an interview on 8/9/07 from 10:00 - 10:45 a.m., Individual #1 did not have a communication choice board at the facility, she was not matching objects with real object pictures at the facility, she did not have a visual calendar, and hazardous areas of the house were not labeled for Individual #1. The QMRP stated they were addressing communication through Individual #1's alternative behavior plan. The alternative behavior plan showed that in response to a verbal prompt, Individual #1 would say "excuse me" while keeping her hands to herself. The alternative behavior plan did not address or include the Speech Language Evaluation recommendations.	W 260		

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W 260	Continued From page 5 The facility failed to ensure Individual #1's IPP was responsive to her communication needs.	W 260		

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MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W249 and W260.	MM212		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 8 of 8 individuals (Individuals #1 - #8) currently residing in the facility. The findings include: An environmental review was conducted on 8/8/07 from 9:25 a.m. - 10:00 a.m., and showed the following concerns: 1. The carpeting in the family room off the kitchen contained a frayed seam running from the window to the kitchen counter which posed a potential trip hazard. 2. The hood of the vent over the kitchen stove was in need of cleaning due to a build up of dust	MM380	MM380 1. The carpet seam is trimmed frequently and will be re glued down to prevent it becoming a trip hazard. 2. The hood vent has been cleaned and is routinely checked as part of the kitchen sanitation check list and the monthly Preventative Maintenonce Check list process. 3. The drawers will be repoired to have stops to prevent the drawers from accidentally being pulled out. 4. The resident identifier did not specify who person #5 is, we have been unable to identify the specific trip hazard but will continue to strive through our monthly safety meetings and our Monthly Preventative Maintenance check list process to maintain all floor surfaces in such a manor as to reduce potential trip hazards. We have in place a monthly Preventative Maintenance check list process with involves the AQMRP, the Maintenance Man and the Administrator. This process is designed to identify maintenance needs as they develop and provide for their timely resolution.	9-14-07

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9-4-07

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MM380	Continued From page 1 and grime. 3. The 4 drawers located to the left of the stove did not have stops to keep them from falling out when opened. The top drawer to the left of the refrigerator also did not have a stop to keep it from falling out when opened. 4. The carpeting at the entry to Individual #5's bedroom was frayed, which posed a potential trip hazard.	MM380		

CCI #1

MM212

Please refer to W240 and W260

MM380

1. The carpeting in the family room

2. The hood of the vent over the kitchen stove

3. The stove drawers

4. The carpeting at Individual #5's bedroom

Keep c survey
dated 8-9-07
MW